V.4.22.19

ST. LOUIS pediatric dentistry

Start them Smiling®

Insurance, Financial & Scheduling Policy

Patient Name:_____ Date of Birth:_____

Our office is committed to delivering the best in world---class healthcare and in helping you maximize your insurance benefits. Because all insurance policies vary, we can only **ESTIMATE** your coverage in good faith and cannot guarantee coverage due to the complexities of insurance contracts. We encourage parents to be knowledgeable of the patient benefits so that together we can better understand your policy. With some carriers our office may be in network, with others out of network, and coverage may change at any time without notification.

We request that you notify our office of any address, phone or insurance changes as soon as they occur.

It is also imperative you be aware of primary and secondary insurance if you have a secondary carrier. We will only file a claim once; if it is denied because of incorrect information given to our office the responsible party will owe the balance.

Our new patient and six month recall appointments include the following services:

- Dental Exam
- Prophylaxis (cleaning)
- Fluoride treatment (polish)
- X-rays (when doctors deem necessary)

Your dental plan may not cover preventive procedures that can save you money later, such as sealants or fluoride treatment. This in no way means these treatments are unnecessary. Our dentists can help you decide what treatments are best for your child.

Our Policy

If you are using a PPO dental insurance plan and have chosen us at the provider of your child's care, it is your responsibility to:

- Provide us with information relative to your claim **PRIOR TO YOUR CHILD'S APPOINTMENT**, including insurance card, number, employer, birth date of policy holder, address and social security number of member and policy holder. This information will initially be requested over the phone when you call to make your child's appointment. This information will also be requested on the Patient Registration Form, which we require you complete online through our website prior to your child's first visit.
- Pay your deductible, co-pay or estimated portion due at the time of service.
- Pay for services not covered by your insurance carrier.

Insurance claims for your carrier are filed as a courtesy to you once at no charge

As a courtesy to our patients, we will bill most insurance companies for services and allow up to 60 days for them to render payment. After this time, interest will be assessed on the account, and you will be responsible for the balance. You will receive a statement from our office stating payment is due upon receipt. Please keep in mind we have already waited 30-60 days from the time of services for your insurance company to render payment.

Your dental plan is designed to **share** in your dental care costs (similar to using a coupon) and may only cover a portion of your

bill. It is meant to help you ensure your investment in your child's dental health. We realize that understanding what your dental plan will cover can be difficult and we would be more than happy to answer any questions we can. ***Please keep in mind your coverage and benefit details are ultimately between you and your insurance company.*** If at any time you have questions, please feel free to call our insurance coordinator. You can also call your insurance company for information.

Payment Options

Your computer estimated patient portion will be due at the time of service for ALL appointments. Our office accepts cash, all major credit cards and Care Credit. We do not accept checks.

Unpaid Balances

If you do not pay the entire balance by the payment due date, a late charge of 1.5% on the balance then unpaid will be assessed each month (if allowed by law).

When your bill is unpaid, a collection agency may be chosen to manage delinquent accounts. In the case you default on payment of your account balance, you agree to pay all collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balances.

Office Scheduling Policy

In order to ensure quality dental care, it is important that both parents and patients understand the manner in which we schedule your appointments. Our goal is to ensure both you and your child have an outstanding dental experience and to value both you and your time. Therefore, we make every effort to stay on or ahead of schedule. Please be aware, we run on time when you run on time and in order to be respectful of all parents and patients in the practice, it is necessary you arrive early to your child's appointment with the completed health history and registration forms.
This will allow your child to get acquainted with our office and time to use the restroom prior to their appointment. Since the vast majority of our patients are of school age, some appointments may require the child to miss some school; however, these are considered excused absences. With continued care, appointments during school can be kept to a minimum.

Our staff works hard to provide the finest dentistry using the most convenient scheduling system possible for you and your child. Because we have families of our own, we understand your scheduling concerns and will do everything we can to ensure your child's treatment goes as smoothly as possible.

Please note the following scheduling guidelines for St. Louis Pediatric Dentistry:

- We require that you cancel or reschedule any appointment **AT LEAST 24 HOURS PRIOR TO YOUR APPOINTMENT TO AVOID A $25.00 CANCELLATION FEE PER PATIENT.** This is not billable to your insurance company.
- If you arrive over 15 minutes late to your child's appointment, you may be asked to reschedule as the delay affects other patients scheduled after you.
- You are required to bring the patient's most current dental insurance card to every appointment.

Patients seen for after-hours emergencies

In the unfortunate event of a true dental emergency which requires a patient be seen at our office after regular business hours an after-hours emergency fee will be charged. This fee is in addition to any necessary treatment fees.

I have read and fully understand my financial responsibilities under this policy and all questions have been answered to my satisfaction. I authorize and release any information including the diagnosis and records of any treatment or examination rendered to my child during the period of such dental care to third party payers. I authorize and request my dental insurance company to pay directly to St. Louis Pediatric Dentistry. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to my child. I have read and agree to the office scheduling and insurance policy above. I confirm I am the legal guardian to the child referenced above. I also confirm that I have read and understand this form or it was read to me and give my voluntary consent.

Signature	**Relationship**
Witness	**Date/Time**